

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12447

12452

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 rural Eden</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>1 Route 1, Box 65 B</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Moses</i> Middle <i>Allen</i> Last <i>Allen</i>				4. DATE OF DEATH Month <i>November</i> Day <i>19</i> Year <i>1957</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-9 1909</i>		9. AGE (In years last birthday) <i>48</i> yrs.	IF UNDER 1 YEAR Months <i>48</i> Days <i>48</i>	IF UNDER 24 HRS. Hours <i>48</i> Min. <i>48</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Allen</i>				14. MOTHER'S MAIDEN NAME <i>LUEVENIA DONALDSON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>265-168385</i>		17. INFORMANT <i>Hospital Records, Peninsula Gen. Hosp</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Kidney</i> DUE TO <i>arteriosclerotic nephrosclerosis</i> Conditions, if any, which gave rise to immediate cause (b) <i>Hypertensive Cardio Vascular Disease</i> (c) <i>20 years</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Contusion and laceration of right leg</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> o. m. <i>25</i> p. m. <i>1957</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Kendrick McCallough</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Kendrick McCallough</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-17-1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Green Acre Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Stewart Funeral Home, Salisbury, Md</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>DATE 19 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

NOV 19 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12453

## CERTIFICATE OF DEATH

12448

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 1939-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>135 South Fourth St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Ames</u> Last <u>Ames</u>				4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasoid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1, 1897</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>CRISFIELD, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE W. AMES</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BROUGHTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>175-05-0990</u>		17. INFORMANT Address <u>Miss ROSIE AMES - 214 N. 4TH ST. - CRISFIELD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Misinterupted Thrombosis</u> <u>450.0</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arricular Fibrillation &amp; Tuberculosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-18</u> 19 <u>57</u> , to <u>11-23</u> 19 <u>57</u> that I last saw the deceased alive on <u>11-23</u> 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. D. Briele</u> M.D.				DATE SIGNED <u>Salisbury, Md. 11-27-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAWSONIA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW &amp; SONS - CRISFIELD, MD.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>12-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harry W. Holloway</u>	

## MIRIAM STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

DEC 5 1957

RECEIVED

12454

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>515 Wailes St</b>				d. STREET ADDRESS <b>515 Wailes St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>ALEXANDER</b> Last <b>AYRES</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>10</b> Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sold Shoes</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Wesley B. Ayres</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Morse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>139-03-3926</b>		17. INFORMANT <b>Mrs. Kathryn W. Ayres (Wife)</b> Address <b>515 Wailes St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Central Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebro-vascular mural lesions</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , to <b>11-10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-10</b> , 19 <b>57</b> , and that death occurred at <b>11:15A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Insley</b>				DATE SIGNED <b>Nov. 11-11-57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>				ADDRESS (Street, city or town, state) <b>Main St. Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fernwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>NOV 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary M. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V.**

NOV 13 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG223 12-20-57 et

Reg. Dist. No.

12450

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>12</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>411 W. Main St.</b>			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Linda Pearl Baker</b>			4. DATE OF DEATH <b>11</b> Month <b>5</b> Day <b>1957</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 26, 1920</b>		9. AGE (In years last birthday) <b>37</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury Md</b>	
13. FATHER'S NAME <b>John William</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Johnson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-14877</b>		17. INFORMANT <b>Sulton Williams</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO (b) <b>Hypertensive C. V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>443X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Earl L. Royer</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>11-8-57</b>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE OF RECORD <b>11-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>	
22d. LOCATION (City, town, or county) <b>Salisbury Md</b>		22e. (State) <b>Md</b>		22f. (County) <b>Wicomico</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank M. West</b>			24a. REC'D BY REGISTRAR <b>NOV 12 1957</b>		
ADDRESS <b>Salisbury Md</b>			24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		

RECEIVED  
NOV 12 1957  
BUREAU V. A.



## CERTIFICATE OF DEATH

Reg. Dist. No.

332

12456

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELBERT</b> Middle <b>MILTON</b> Last <b>BARBON</b>				4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 8, 1908</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>23</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman or Agent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William T. Barbon</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Lloyd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-9659</b>		17. INFORMANT Address <b>Mrs. Elizabeth G. Barbon, Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Artery Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>1 yr</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6/22, 1957</b> to <b>11/23, 1957</b> that I last saw the deceased alive on <b>11/22/1957</b> , and that death occurred at <b>4:15 AM</b> , from the cause and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>Nov. 25, 1957</b>							
ACTUAL SIGNATURE <b>David J. Gilmore</b> M.D. <b>Salisbury, Md.</b>							
PHYSICIAN'S NAME (Type) <b>DAVID J. GILMORE SALISBURY, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11-25-57</b>		24b. REGISTRAR'S SIGNATURE <b>May W. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: *William V. Johnson*  
2. Sex: *Male*  
3. Age: *67*  
4. Date of Birth: *1888*  
5. Date of Death: *11/27/57*  
6. Place of Death: *Home*  
7. Cause of Death: *Coronary Arteriosclerosis*  
8. Physician: *Dr. [illegible]*  
9. Burial Place: *Greenwood Cemetery*  
10. Registrar: *[illegible]*

*Coronary Arteriosclerosis*  
*Greenwood Cemetery*

**RECEIVED**  
NOV 27 1957  
BUREAU V. 3

*David J. Johnson*  
*11/27/57*  
*11/27/57*

12457

## CERTIFICATE OF DEATH

Reg. Dist. No.

227

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Nanticoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Robert W. Barclay</u>				4. DATE OF DEATH <u>November 15 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-89</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster House</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Barclay</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Barclay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>228-03-3446</u>			
17. INFORMANT <u>Lucy Barclay</u>				Address <u>Nanticoke</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Anterior Septal</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u>Definite</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-2-</u> , 19 <u>57</u> , to <u>11-15-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 Nov</u> , 19 <u>57</u> , and that death occurred at <u>12:00</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Purnell</u>				ADDRESS (Street, city or town, state) <u>652 W. Main St. Salisbury, Md.</u>			
DATE SIGNED <u>18 Nov 57</u>							
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messersmith, Birchove, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25</u>			
ADDRESS <u>Salisbury, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>May Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO REGISTRAR: This certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

NOV 25 1957

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No.

12458

33 ✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN lb <u>12 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Souvenir</u> <u>BARCLAY</u>		4. DATE OF DEATH Month Day Year <u>November 19, 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/91</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Printing Factory</u>	9c. BIRTHPLACE (State or foreign country) <u>Md.</u>
10a. FATHER'S NAME <u>Thomas A. Barclay</u>		10b. MOTHER'S MAIDEN NAME <u>Octavia Conway</u>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unknown) (If yes, give war or dates of service) <u>No</u>		12. SOCIAL SECURITY NO. <u>214-18-4640A</u>	
13. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis with Cholelithiasis. Benign Prostatic Hypertrophy</u>		14. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE _____ M.D. _____			
PHYSICIAN'S NAME (Type) <u>David J. Schwore M.D. Salisbury Md.</u> <u>Nov. 20, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>11/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nantuxet Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Nantuxet, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messier, Brooke, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mar. Holloway</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Case No. 1000

MASSACHUSETTS

CITY OF BOSTON

DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY NUMBER

BUREAU V. 5

DEC 3 1957

RECEIVED



12459 CERTIFICATE OF DEATH

12454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>X1 DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSP.</u>				d. STREET ADDRESS <u>R 7 D # 1</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE EDNA BELLMAN</u>				4. DATE OF DEATH Month Day Year <u>November 19, 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-4-1897</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES BROWN</u>				14. MOTHER'S MAIDEN NAME <u>EDNA OLIPHANT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CHARLES BELLMAN-DELMAR, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3.2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>11-19</u> , 19 <u>57</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William B. Ellis</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR-DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-S-Marrill Co - Delmar, Del</u>				24a. REC'D BY REGISTRAR DATE <u>22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		M		65		JAN 15 1885		BALTIMORE, MD		RETIRED	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
1234 E. BALTIMORE ST.		NOV 15 1950		BALTIMORE, MD		HEART DISEASE		NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE		PLACE		COUNTY		STATE	
J. H. HARRIS		J. H. HARRIS		NOV 15 1950		BALTIMORE		BALTIMORE		MD	

BUREAU V. S.

NOV 22 1950

RECEIVED

12460

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GEN. Hosp.</u>				d. STREET ADDRESS <u>Rt. 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Edward</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 19 1865</u>	
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Brown</u>				14. MOTHER'S MAIDEN NAME <u>LOVEY J. HEARN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no for unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>I. FRANK BROWN - Salisbury Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>931X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>11-3</u> <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-23</u> , 19 <u>57</u> , to <u>Oct 1-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-3</u> , 19 <u>57</u> , and that death occurred at <u>1:07 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>A.C. Mitchell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>A.C. Mitchell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL Specify <u>BURIAL</u>		22b. DATE THEREOF <u>11/5/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will J Johnson</u> ADDRESS <u>Salisbury, Md</u>				24a. REC'D BY REGISTRAR <u>11-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm W. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO REGISTRAR: The law requires that the death certificate be executed within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Male		White		21	
Date of Birth		Place of Birth		Cause of Death	
Dec 29 1935		Maryland		Diphtheria	
Date of Death		Place of Death		Occupation	
Jan 3 1936		Hospital		None	
Time of Death		Physician		Burial Place	
11:30 A.M.		Dr. J. H. Brown		St. John's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Coroner	
J. H. Brown		[Signature]		[Signature]	

BUREAU V. 8

JAN 8 1957

RECEIVED

St. John's Cemetery  
Baltimore, Md.

12461

## CERTIFICATE OF DEATH

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>Shiloh St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BRYAN</b> Middle <b>OLEN</b> Last <b>BURGETT</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>th 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1900</b>		9. AGE (In years lost birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.	IF UNDER 24 HRS. Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant (Grocery Store)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Business</b>		11. BIRTHPLACE (State or foreign country) <b>Goff Ka.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Hesikaih Burgett</b>				14. MOTHER'S MAIDEN NAME <b>Laura Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>511-09-7104</b>		17. INFORMANT Address <b>Mrs. Thomas Faison (Daughter) 305 S. Haven Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture Aortic Aneurysm; Abdominal Dist</b> <b>451x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>56</b> , to <b>death</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-20-57</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fruitland, Md.</b> DATE SIGNED <b>Nov. 21/57</b>							
ACTUAL SIGNATURE <b>Lee L Lawry</b>				M.D. <b>Fruitland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>				<b>Fruitland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>NOV 25</b>		24b. REGISTRAR'S SIGNATURE <b>Mary P. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



NEW YORK STATE DEPARTMENT OF HEALTH—BIRMINGHAM, 18

NOV 25 1957

RECEIVED



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12457

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>one day</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Nassau</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sea Cliff</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jude</b>		First <b>J.</b> Middle <b>J.</b> Last <b>Chlupsa</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 2, 1938</b>		9. AGE (In years last birthday) <b>19</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (State or foreign country) <b>New York City, NY</b>	
13. FATHER'S NAME <b>Siegfried Chlupsa</b>		14. MOTHER'S MAIDEN NAME <b>Mary Schmitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Whitting Funeral Home, Glen Head, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Crushed Chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) <b>Fracture left tibia and femur</b>				INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs</b> <b>26 hrs</b> <b>26 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>816x</b>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto and Truck Accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>10:30 PM 11-15-57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>	
20f. (City or town) <b>Rt 13</b>		20g. (County) <b>Wicomico</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>		DATE SIGNED <b>11-17-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>23 Nov. 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cem. of the Holy Rood Westbury, New York</b>	
22d. LOCATION (City, town, or county) <b>Glen Head, New York</b>		(State) <b>NY</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. J. Whitting</b>		ADDRESS <b>Glen Head, New York</b>		24. REC'D BY REGISTRAR <b>Nov 25 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>					

RECEIVED

NOV 25 1957

BUREAU V. 2

12463

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City 23x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>8 N. DIVISION ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clifford</u> Middle <u>Potts</u> Last <u>Cropper</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 7, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. WATERMAN Fishing COMMERCIAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Cropper</u>		14. MOTHER'S MAIDEN NAME <u>Sally M. Hastings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS. C. P. CROPPER - OCEAN CITY, MD.</u>	
17. INFORMANT <u>MRS. C. P. CROPPER - OCEAN CITY, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>580x Acute Leptospirosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 week</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>57</u> , to <u>9-5-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>57</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilbur R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>MEDICAL CENTER, SALISBURY, MD.</u>	
PHYSICIAN'S NAME (Type) <u>Wilbur R. Ellis, Jr.</u>		DATE SIGNED <u>MEDICAL CENTER, SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/7/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Md.</u>		ADDRESS <u>Normant Baker</u>	
24a. REC'D BY REGISTRAR <u>DATE 11-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

# CERTIFICATE OF DEATH

Form No. 10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

12/14/57

8th Division ST

10/15

Oct 5 1957

67

Salisbury M. Hastings

Thomas J. Cropper

Mrs. C. P. Cropper - Ocean City, Md.

NO

BUREAU V. 1

NOV 8 1957

RECEIVED

Medical Center

Wilbur R. Ellis, Jr.

Journal 11/17/1957 EVERGREEN Cem.

Bill Johnson Co. Salisbury, Md.

12464

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>XO</b> <b>Mardela</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>Bridge St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>DARBY</b> Last <b>DARBY</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18th</b> Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1885</b>		9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>22</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Laborer)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contracter &amp; Builder</b>		11. BIRTHPLACE (State or foreign country) <b>Mardela, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Job Darby</b>				14. MOTHER'S MAIDEN NAME <b>Mona Wille Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Mona Darby (Wife) Bridge St. Mardela, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> <b>Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/14/57</b> , 19 <b>57</b> , to <b>11/18/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/18/57</b> , 19 <b>57</b> , and that death occurred at <b>11:45 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>Nov. 19/57</b>							
ACTUAL SIGNATURE <b>Fred R. Gremse</b>				M.D. <b>Salisbury, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gremse</b>				402 S. Division St. Salisbury, Md. Nov. 19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-</b>		22b. DATE THEREOF <b>Nov. 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemestery</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>NOV 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

BUREAU V. S.

NOV 21 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please  
in Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12465

## CERTIFICATE OF DEATH

12460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 9 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Riverside Nursing &amp; Convalescent Home</u>				d. STREET ADDRESS <u>xo Pittsville</u>			
3. NAME OF DECEASED (Type or print) First <u>Annice</u> Middle <u>M.</u> Last <u>Dennis</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25-1874</u>	
9. AGE (In years Jan birthday) <u>83 1/2</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min. <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsville, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>MD</u>			
13. FATHER'S NAME <u>Robert Brittingham</u>				14. MOTHER'S MAIDEN NAME <u>Amelia White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>William E. Dennis</u>				Address <u>Snow Hill, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>degenerative heart disease</u> DUE TO (c) <u>5 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>8/17/57</u> to <u>11/24/57</u> , that I last saw the deceased alive on <u>11/24/57</u> , and that death occurred at <u>5:17</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, MD</u> DATE SIGNED <u>11/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Earl M. Beardsley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharon Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsville MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Dennis</u>				ADDRESS <u>Snow Hill, MD</u>		24. REC'D BY REGISTRAR <u>DATE 27 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12466

## CERTIFICATE OF DEATH

12466

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>			
c. LENGTH OF STAY IN 1b <u>30 days</u>				d. STREET ADDRESS <u>105 CAROLYN ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SALLIE LOUISE DILL</u>				4. DATE OF DEATH <u>NOVEMBER 14 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 26, 1864</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>EASTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID DUYNING</u>				14. MOTHER'S MAIDEN NAME <u>MARY SATTERFIELD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MRS. NELLIE TORPEY</u> Address <u>OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diverticulitis, with peritonitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOVEMBER 11, 1957</u> , to <u>NOVEMBER 14, 1957</u> , that I last saw the deceased alive on <u>NOVEMBER 14, 1957</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond M. Youl</u> M.D.				ADDRESS (Street, city or town, state) <u>707 Camden, Salisbury, Md.</u> DATE SIGNED <u>11-14-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. Embury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. A. Embury</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>NOV 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. 3

NOV 19 1957

RECEIVED

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint, illegible markings.

## 12467 CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> <b>3 Vol-4</b>	
f. STREET ADDRESS <b>916 Duncan Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Donnelly</b> Last <b>Donnelly</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 12, 1881</b>
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Frederick Ellinghaus</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Bornhorn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Metastases</b> <b>176 X</b> DUE TO <b>Carcinoma of Vagina</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6-8 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 23, 19 57</b> , to <b>Nov. 10, 19 57</b> , that I last saw the deceased alive on <b>Nov. 10, 19 57</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>		DATE SIGNED <b>Nov. 10, 1957</b>	
ACTUAL SIGNATURE <b>G. Kosmahly</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cent.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		ADDRESS <b>3000 E. Baltimore St.</b>	
24a. REC'D BY REGISTRAR DATE <b>11/12/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary J. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



NOV 13 1957

RECEIVED



## 12468 CERTIFICATE OF DEATH

12468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u> 1982.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>BECK FORD AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lee</u> Last <u>DONOHUE</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 20, 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u></u>			
13. FATHER'S NAME <u>Brandon Donahue</u>				14. MOTHER'S M maiden NAME <u>Lucille Belle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>C</u>			
17. INFORMANT <u>Ms. Brandon Donahue P. Anne</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Partial fetal atelectasis</u> <u>762.5</u> DUE TO <u>Prematurity (Weight 2 lbs 14 oz)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mother had severe pre-eclampsia &amp; hypertension</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) (County) (State) <u></u>							
21. I certify that I attended the deceased from <u>Nov 20</u> , 19 <u>57</u> , to <u>Nov 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. V. Gunderson Jr.</u> M.D.				DATE SIGNED <u>Nov 24, 1957</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R Wilson</u>				ADDRESS <u>Princess Anne Md</u>			
24a. REC'D BY REGISTRAR <u>Nov 25 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Mary K Holloway</u>			

2082404XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF PHYSICIAN		14. NAME OF CLERGYMAN		15. NAME OF MINISTER	
16. NAME OF CHURCH		17. NAME OF CEMETERY		18. NAME OF FUNERAL HOME	
19. NAME OF BURIAL PLACE		20. NAME OF INTERMENT		21. NAME OF CREMATION	
22. NAME OF CREMATION		23. NAME OF CREMATION		24. NAME OF CREMATION	
25. NAME OF CREMATION		26. NAME OF CREMATION		27. NAME OF CREMATION	
28. NAME OF CREMATION		29. NAME OF CREMATION		30. NAME OF CREMATION	
31. NAME OF CREMATION		32. NAME OF CREMATION		33. NAME OF CREMATION	
34. NAME OF CREMATION		35. NAME OF CREMATION		36. NAME OF CREMATION	
37. NAME OF CREMATION		38. NAME OF CREMATION		39. NAME OF CREMATION	
40. NAME OF CREMATION		41. NAME OF CREMATION		42. NAME OF CREMATION	
43. NAME OF CREMATION		44. NAME OF CREMATION		45. NAME OF CREMATION	
46. NAME OF CREMATION		47. NAME OF CREMATION		48. NAME OF CREMATION	
49. NAME OF CREMATION		50. NAME OF CREMATION		51. NAME OF CREMATION	
52. NAME OF CREMATION		53. NAME OF CREMATION		54. NAME OF CREMATION	
55. NAME OF CREMATION		56. NAME OF CREMATION		57. NAME OF CREMATION	
58. NAME OF CREMATION		59. NAME OF CREMATION		60. NAME OF CREMATION	
61. NAME OF CREMATION		62. NAME OF CREMATION		63. NAME OF CREMATION	
64. NAME OF CREMATION		65. NAME OF CREMATION		66. NAME OF CREMATION	
67. NAME OF CREMATION		68. NAME OF CREMATION		69. NAME OF CREMATION	
70. NAME OF CREMATION		71. NAME OF CREMATION		72. NAME OF CREMATION	
73. NAME OF CREMATION		74. NAME OF CREMATION		75. NAME OF CREMATION	
76. NAME OF CREMATION		77. NAME OF CREMATION		78. NAME OF CREMATION	
79. NAME OF CREMATION		80. NAME OF CREMATION		81. NAME OF CREMATION	
82. NAME OF CREMATION		83. NAME OF CREMATION		84. NAME OF CREMATION	
85. NAME OF CREMATION		86. NAME OF CREMATION		87. NAME OF CREMATION	
88. NAME OF CREMATION		89. NAME OF CREMATION		90. NAME OF CREMATION	
91. NAME OF CREMATION		92. NAME OF CREMATION		93. NAME OF CREMATION	
94. NAME OF CREMATION		95. NAME OF CREMATION		96. NAME OF CREMATION	
97. NAME OF CREMATION		98. NAME OF CREMATION		99. NAME OF CREMATION	
100. NAME OF CREMATION		101. NAME OF CREMATION		102. NAME OF CREMATION	

RECEIVED  
NOV 29 1957  
BUREAU V. B.

## 12469 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON</u> <u>23X2.2</u>	
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RETTA MAE DOUGHTY</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 13 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 17 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SILAS WISE</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-20-8501</u>	
17. INFORMANT Address <u>LEON DOUGHTY, STOCKTON, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic nephritis</u> DUE TO (c) <u>uremia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOVEMBER 10 1957</u> to <u>NOVEMBER 13 1957</u> , that I last saw the deceased alive on <u>NOVEMBER 13 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/13/57</u>			
ACTUAL SIGNATURE <u>William R. Ellis Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS SR.</u> <u>SALISBURY MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u> ADDRESS <u>Pocomoke, MD.</u>		24. REC'D BY REGISTRAR <u>NOV 13 1957</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

NOV 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

UNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12465

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>near Mardela</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
		d. STREET ADDRESS <b>1103 E, Church St.</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fullmore</b> Middle <b>E. Dryden</b> Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-1905</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filling station operator</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Dryden</b>		14. MOTHER'S MAIDEN NAME <b>Cora King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Margaret Dryden Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide Poisoning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> a.m. <b>2</b> p.m. <b>19 57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) <b>Mardela</b> (County) <b>Wicomico</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-5-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin Wilson</b>		24a. REC'D BY REGISTRAR <b>NOV 7 1957</b>	
ADDRESS <b>Princess Anne, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Bellamy</b>	



RECEIVED

NOV 7 1957

BUREAU V. 2

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. LENGTH OF STAY IN 1b <b>28 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>R.R. 2</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>PAUL Henry DAYDEN</b>				4. DATE OF DEATH <b>NOVEMBER 8 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 29 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Dryden</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Warwick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Non -</b>		17. INFORMANT <b>Mrs Ruric Ford</b>		Address <b>Princess Anne, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Heart Disease</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia, Hypochromic - Severe</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10/12</b> , 19 <b>57</b> , to <b>11/8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/8</b> , 19 <b>57</b> , and that death occurred at <b>8:30</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David J. Salovey</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury Md</b> DATE SIGNED <b>Nov. 8, 1957</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Hannon</b> ADDRESS <b>Princess Anne</b>				24a. REC'D BY REGISTRAR <b>Nov 14 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME WHITE  
SEX MALE  
DATE OF BIRTH 10/18/1915  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH 11/27/1957  
PLACE OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESS  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF CLERK

*George Washington*  
*Washington*

*George Washington*

BUREAU V. S.

NOV 14 1957

RECEIVED

## 12471 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shopton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SHIRLEY</u> Middle <u>ANN</u> Last <u>DUNN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) yrs. <u>3</u> IF UNDER 1 YEAR Months <u>3</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE DUNN</u>		14. MOTHER'S MAIDEN NAME <u>ADH RUARK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>George Dunn</u> Address <u>Shopton Md</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>768.0</u> DUE TO <u>(Fever, icterus, white count 24,000)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx 2+ hours</u>
---	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/16, 1957, to 11/18, 1957, that I last saw the deceased alive on 11/18/57, 1957, and that death occurred at 4:10 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Alfred C. Kells</u> M.D.	DATE SIGNED <u>Medical Center</u>
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Burton</u>	22d. LOCATION (City, town, or county) (State) <u>Shopton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Garmel</u> ADDRESS <u>Shopton Md</u>		24a. REC'D BY REGISTRAR <u>NOV 21 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082284 XV7

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF STATE CLERK	
25. SIGNATURE OF SECRETARY		26. SIGNATURE OF ASSISTANT SECRETARY		27. SIGNATURE OF CHIEF CLERK	
28. SIGNATURE OF DEPUTY CHIEF CLERK		29. SIGNATURE OF RECORDS MANAGER		30. SIGNATURE OF FILE CLERK	
31. SIGNATURE OF MAIL ROOM		32. SIGNATURE OF TELEPHONE ROOM		33. SIGNATURE OF RECEPTIONIST	
34. SIGNATURE OF CLEANING PERSONNEL		35. SIGNATURE OF SECURITY PERSONNEL		36. SIGNATURE OF OTHER PERSONNEL	
37. SIGNATURE OF VOLUNTEERS		38. SIGNATURE OF BOARD OF DIRECTORS		39. SIGNATURE OF BOARD OF SUPERVISORS	
40. SIGNATURE OF BOARD OF TRUSTEES		41. SIGNATURE OF BOARD OF MANAGERS		42. SIGNATURE OF BOARD OF COMMISSIONERS	
43. SIGNATURE OF BOARD OF CENSORS		44. SIGNATURE OF BOARD OF EXAMINERS		45. SIGNATURE OF BOARD OF APPEALS	
46. SIGNATURE OF BOARD OF REVIEW		47. SIGNATURE OF BOARD OF INVESTIGATION		48. SIGNATURE OF BOARD OF INQUIRY	
49. SIGNATURE OF BOARD OF CONCILIATION		50. SIGNATURE OF BOARD OF RECONCILIATION		51. SIGNATURE OF BOARD OF REFORMATION	
52. SIGNATURE OF BOARD OF REDEMPTION		53. SIGNATURE OF BOARD OF REDEMPTION		54. SIGNATURE OF BOARD OF REDEMPTION	
55. SIGNATURE OF BOARD OF REDEMPTION		56. SIGNATURE OF BOARD OF REDEMPTION		57. SIGNATURE OF BOARD OF REDEMPTION	
58. SIGNATURE OF BOARD OF REDEMPTION		59. SIGNATURE OF BOARD OF REDEMPTION		60. SIGNATURE OF BOARD OF REDEMPTION	
61. SIGNATURE OF BOARD OF REDEMPTION		62. SIGNATURE OF BOARD OF REDEMPTION		63. SIGNATURE OF BOARD OF REDEMPTION	
64. SIGNATURE OF BOARD OF REDEMPTION		65. SIGNATURE OF BOARD OF REDEMPTION		66. SIGNATURE OF BOARD OF REDEMPTION	
67. SIGNATURE OF BOARD OF REDEMPTION		68. SIGNATURE OF BOARD OF REDEMPTION		69. SIGNATURE OF BOARD OF REDEMPTION	
70. SIGNATURE OF BOARD OF REDEMPTION		71. SIGNATURE OF BOARD OF REDEMPTION		72. SIGNATURE OF BOARD OF REDEMPTION	
73. SIGNATURE OF BOARD OF REDEMPTION		74. SIGNATURE OF BOARD OF REDEMPTION		75. SIGNATURE OF BOARD OF REDEMPTION	
76. SIGNATURE OF BOARD OF REDEMPTION		77. SIGNATURE OF BOARD OF REDEMPTION		78. SIGNATURE OF BOARD OF REDEMPTION	
79. SIGNATURE OF BOARD OF REDEMPTION		80. SIGNATURE OF BOARD OF REDEMPTION		81. SIGNATURE OF BOARD OF REDEMPTION	
82. SIGNATURE OF BOARD OF REDEMPTION		83. SIGNATURE OF BOARD OF REDEMPTION		84. SIGNATURE OF BOARD OF REDEMPTION	
85. SIGNATURE OF BOARD OF REDEMPTION		86. SIGNATURE OF BOARD OF REDEMPTION		87. SIGNATURE OF BOARD OF REDEMPTION	
88. SIGNATURE OF BOARD OF REDEMPTION		89. SIGNATURE OF BOARD OF REDEMPTION		90. SIGNATURE OF BOARD OF REDEMPTION	
91. SIGNATURE OF BOARD OF REDEMPTION		92. SIGNATURE OF BOARD OF REDEMPTION		93. SIGNATURE OF BOARD OF REDEMPTION	
94. SIGNATURE OF BOARD OF REDEMPTION		95. SIGNATURE OF BOARD OF REDEMPTION		96. SIGNATURE OF BOARD OF REDEMPTION	
97. SIGNATURE OF BOARD OF REDEMPTION		98. SIGNATURE OF BOARD OF REDEMPTION		99. SIGNATURE OF BOARD OF REDEMPTION	
100. SIGNATURE OF BOARD OF REDEMPTION		101. SIGNATURE OF BOARD OF REDEMPTION		102. SIGNATURE OF BOARD OF REDEMPTION	

BUREAU V. S.

NOV 21 1957

RECEIVED



12472

## CERTIFICATE OF DEATH

Reg. Dist. No.

382

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>4 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Riggin</u> Last <u>Godfrey</u>				4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 25, 1886</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS STATION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		9. AGE (In years last birthday) <u>71</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John W. Riggin</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martha Morris</u> Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>Plastric Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophageal Varices</u> DUE TO <u>Cirrhosis, Laennec's of liver</u> (c) <u>2-3 yrs?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>57</u> , to <u>11/3</u> , 19 <u>57</u> that I last saw the deceased alive on <u>11/3</u> , 19 <u>57</u> , and that death occurred at <u>5:12</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>321 S. Div. St.</u>			
DATE SIGNED <u>11/3/57</u>							
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>				ADDRESS <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11/6/1957</u>		<u>PARSONS CEMETERY</u>		<u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-5-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased John W. Rice		Date of Birth Jan 2, 1910	
Sex Male		Race White	
Usual Residence 415 Stephen Avenue Baltimore, Md.		Present Residence 415 Stephen Avenue Baltimore, Md.	
Cause of Death None		Date of Death Jan 2, 1957	
Place of Death Home		Signature of Physician [Signature]	
Name of Informant Martha Rice		Address of Informant 415 Stephen Avenue Baltimore, Md.	
Signature of Informant [Signature]		Date of Statement Jan 2, 1957	

BUREAU V. 3

NOV 7 1957

RECEIVED

12473 CERTIFICATE OF DEATH

12469

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke - RURAL</u> 23 x 1.2	
c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		d. STREET ADDRESS <u>Pocomoke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>HALL</u>		4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28 1875</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL F. HALL</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BRIDDELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WILLIS C. HALL, POCOMOKE, MARYLAND</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11-2-57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-28</u> , 1957, to <u>11-2</u> , 1957, that I last saw the deceased alive on <u>11/2</u> , 1957, and that death occurred at <u>1:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willis C. Hall</u> M.D.		DATE SIGNED <u>1-2-57</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u> ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 5 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

RECEIVED  
NOV 5 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12474

## CERTIFICATE OF DEATH

Reg. Dist. No.

12470

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>Williamsburg 09X1-2</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Sutcliffe</b> Last <b>Harding</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1908</b>	
9. AGE (In years lost birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>49</b> Days <b>14</b> Hours <b>57</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Delmar, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Norman Sutcliffe</b>		14. MOTHER'S MAIDEN NAME <b>Wheatley (Roberta)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Deer's Head Hospital Records, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 28, 19 57</b> to <b>November 14, 19 57</b> , that I last saw the deceased alive on <b>November 14, 19 57</b> , and that death occurred at <b>1:50 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/14/57</b> ACTUAL SIGNATURE <b>L. V. Madave</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Madave, M. D.</b> <b>Deer's Head State Hospital</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>November 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hurlock, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. J. Frampton and Son</b> <b>Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11-19-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Hollomay</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

3 should be detached for use as the burial-transit permit. Then please remove carbon papers. registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS			

12471 337

12475

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>90 Riverside Nursing Home, Camden Court</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>Harrison</b> Last <b>Harrison</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1878</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew J. Killmon</b>				14. MOTHER'S MAIDEN NAME <b>Betty Crockett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Claude Parso Salisbury, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 yr?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury</b>				20g. (County) <b>Salisbury</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Nov. 21, 1957</b> to <b>Nov 22, 1957</b> , that I last saw the deceased alive on <b>Nov 21, 1957</b> , and that death occurred at <b>6:30 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rufus S. Gardner, Jr.</b>				ADDRESS (Street, city or town, state) <b>321 S. Div. St., Salisbury, Md.</b>			
DATE SIGNED <b>11/22/57</b>				DATE <b>NOV 26 1957</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner, Jr.</b>				ADDRESS <b>321 S. Division St., Salisbury, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>11/24/57</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Onancock Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Onancock, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Onancock</b>				24a. REC'D BY REGISTRAR <b>Nov 26 1957</b>			
ADDRESS <b>Onancock, Virginia</b>				24b. REGISTRAR'S SIGNATURE <b>Wm. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

DATE OF DEATH

PLACE TO DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

BUREAU V. S.

NOV 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

12475 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12475

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>710 Alvin Ave</b>		d. STREET ADDRESS <b>710 Alvin Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JUANITA ISABELLA HOLLOWAY</b>		4. DATE OF DEATH <b>NOV. 3 rd 19 57</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1917</b>	
9. AGE (In years last birthday) <b>40 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work (Office Clerk)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>W. Austin Moore</b>		14. MOTHER'S MAIDEN NAME <b>Ella M. Adkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b>	
17. INFORMANT <b>Mr. William F. Holloway (Husband)</b>		Address <b>710 Alvin Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia by Hanging</b> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Depression</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>10 11 3 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. City or town <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. RECEIVED BY REGISTRAR <b>NOV 7 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary F. Holloway</b>	

RECEIVED

NOV 7 1957

BUREAU V. S.



12477

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>82</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>VIRGINIA</b> Last <b>INSLEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19th</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1895</b>
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR: Months <b>3</b> Days <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator (Shirt Factory)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Employee</b>	
11. BIRTHPLACE (State or foreign country) <b>Athol, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Riffin</b>		14. MOTHER'S MAIDEN NAME <b>Roxie Twilley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Charlotte Willey (Daughter)</b>		Address <b>Mardela, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-19</b> , 19 <b>57</b> , to <b>11-19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-19</b> , 19 <b>57</b> , and that death occurred at <b>6:10 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>W. Ellis Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis Jr.</b>		Medical Center - Salisbury, Maryland Nov. 19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 23, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>NOV 21 1957</b>	
		24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

BUREAU V. S.

NOV 21 1957

RECEIVED

12474

12478  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Madison Street,</b>		d. STREET ADDRESS <b>607 Madison Street,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ruth Mae Jackson</b>		4. DATE OF DEATH <b>Nov. 2, 1957.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1891.</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Factory.</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles Co, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Walter Key Welch</b>		14. MOTHER'S MAIDEN NAME <b>Adeal Higgs.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Eva Harrington (Sister)</b>		Address <b>607 Madison St. Salisbury, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Abdominal Carcinomatosis</b> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-6-1957</b> , to <b>19-11-1957</b> , that I last saw the deceased alive on <b>10-6-1957</b> , and that death occurred at <b>12:30 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland.</b> DATE SIGNED <b>11-4-57</b>			
ACTUAL SIGNATURE <b>H. B. Brule</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Henry A. Briele</b> <b>Medical Center, Salisbury, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 5, 57.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bivalve Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bivalve Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co. Salisbury, Maryland.</b>		ADDRESS <b>Salisbury, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>NOV 7 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, or the registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers, and fill in Nos. 1 and 2 should be filled with the name of the funeral home or registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

BUREAU V. S.

NOV 7 1957

RECEIVED

12479

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East New Market</b> <b>09x2.2</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Lucinda</b> Last <b>Jenkins</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1893</b>		9. AGE (In years lost birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Banks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Deer's Head Hospital Records, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>416x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Rheumatic heart disease</b> DUE TO <b>?</b> (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b> <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Salisbury, Maryland</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12, 19 57</b> to <b>Nov. 14, 19 57</b> , that I last saw the deceased alive on <b>Nov. 14, 19 57</b> , and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/15/57</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b> <b>Deer's Head State Hospital</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11-19-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

NOV 21 1957

RECEIVED

12480

## CERTIFICATE OF DEATH

12478  
337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>--</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Edward</b> Last <b>Legar</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Legar</b>				14. MOTHER'S MAIDEN NAME <b>Mary Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Deer's Head Hospital, Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paget's disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Nov. 26, 1956</b> , to <b>Nov. 24, 1957</b> , that I last saw the deceased alive on <b>Nov. 24, 1957</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/25/57</b> ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D. PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b> <b>Deer's Head State Hospital</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 28, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. James Cemetery</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Bullock</b>			ADDRESS <b>Havre de Grace</b>	24a. RECEIVED BY REGISTRAR DATE <b>DEC 2 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary K. Halloran</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

12481

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u> 2342.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>712 SECOND STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTIE A. LOCKERMAN</u>		4. DATE OF DEATH Month Day Year <u>November 4 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 22, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM C. BONNEVILLE</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA HANCOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>MRS CLEORA B. CHURCHVILLE, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 25, 1957</u> to <u>Nov. 4, 1957</u> , that I last saw the deceased alive on <u>Nov 3, 1957</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Egan</u> M.D.		DATE SIGNED <u>Nov 4, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u> ADDRESS <u>POCOMOKE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Harry H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 5

NOV 7 1957

RECEIVED



12482

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.A.A. Pen. Gen. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
f. STREET ADDRESS <b>R.D. # 5 (Cedar Heights Lane)</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>LEONARD</b> Last <b>MARSHALL</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29th</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14th, 1895</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private Club (Steward)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hamilton Nwe York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Annie Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Amy M. Marshall (Wife)</b> Address <b>R.D. # 5 Cedar Heights Lane - Quantico Rd. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>✓</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> , 19____, to <b>death</b> , 19____, that I last saw the deceased alive on <b>11-29-57</b> , 19____, and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fruitland, Md</b> DATE SIGNED <b>Nov. 30 1957</b>			
ACTUAL SIGNATURE <b>Lee L Lawry</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>		<b>Fruitland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 1st, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meth. Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bivalve, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 2 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary H Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MASS.		COUNTY OF	
CITY OF		TOWN OF	
DECEASED		AGE	
SEX		MARRIAGE	
DATE OF BIRTH		DATE OF DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
EDUCATION		MANNER OF DEATH	
RELIGION		SIGNATURE OF PHYSICIAN	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

BUREAU V. S.

DEC 2 1957

RECEIVED

12483

## CERTIFICATE OF DEATH

1247032

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> ✓	
c. LENGTH OF STAY IN 1b <u>2 1/2 weeks</u>		d. STREET ADDRESS <u>Fourth Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>318 Barclay Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>T.</u> Last <u>MASON</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George T. Clayton</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Mason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Linwood Farlow, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 yr -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 19</u> 19 <u>57</u> , to <u>Nov 19</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 19</u> 19 <u>57</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Salisbury, Md. 21780</u> DATE SIGNED <u>Nov 25 1957</u>	
ACTUAL SIGNATURE <u>Earl M. Beardsley</u> M.D.		PHYSICIAN'S NAME (Type) <u>EARL M. BEARDSLEY</u> <u>SALISBURY, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-57</u>	22c. NAME OF CEMETERY OR CREMATION <u>John M. Tavior Mem.</u>	22d. LOCATION (City, town, or county) (State) <u>Temperanceville, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 25 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, or the registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 100

<p>1. NAME OF DECEASED                  [Faint handwritten name]</p>		<p>2. SEX                  [Faint handwritten sex]</p>	
<p>3. AGE                  [Faint handwritten age]</p>		<p>4. DATE OF BIRTH                  [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH                  [Faint handwritten place]</p>		<p>6. DATE OF DEATH                  [Faint handwritten date]</p>	
<p>7. TIME OF DEATH                  [Faint handwritten time]</p>		<p>8. PLACE OF DEATH                  [Faint handwritten place]</p>	
<p>9. CAUSE OF DEATH                  [Faint handwritten cause]</p>		<p>10. MEDICAL HISTORY                  [Faint handwritten history]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint handwritten signature]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint handwritten signature]</p>	
<p>13. SIGNATURE OF WITNESS                  [Faint handwritten signature]</p>		<p>14. SIGNATURE OF DECEASED                  [Faint handwritten signature]</p>	

BUREAU V. S.

NOV 25 1957

RECEIVED

12484

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> 23x2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>811 Baltimore Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>John</u> Last <u>Massey</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
13. FATHER'S NAME <u>DANIEL J. MASSEY</u>				14. MOTHER'S MAIDEN NAME <u>HESTER MORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS. R. S. MASSEY OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis &amp; Uremia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>57</u> , to <u>Nov 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>57</u> , and that death occurred at <u>8:57 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>NOV 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

Decedent's Name \_\_\_\_\_

Sex \_\_\_\_\_

Age \_\_\_\_\_

Date of Birth \_\_\_\_\_

Place of Birth \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Education \_\_\_\_\_

Religion \_\_\_\_\_

Usual Residence \_\_\_\_\_

Place of Death \_\_\_\_\_

Time of Death \_\_\_\_\_

Cause of Death \_\_\_\_\_

Manner of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

BUREAU V. S.

NOV 14 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health. This designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812481											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 20e Film 225 11-29-57 ams 12485 Items 3,5,6,8 Film G222 11-21-57 et, From Birth Cert. No. 335											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Athol</b>				c. LENGTH OF STAY in 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Athol</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Athol</b>						d. STREET ADDRESS <b>Athol</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oxalene</b> Middle <b>Deliese</b> Last <b>McCoy</b>						4. DATE OF DEATH Month <b>11-</b> Day <b>15-</b> Year <b>19 57</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 7, 1957</b>		9. AGE (In years last birthday) yrs. <b>2</b> mos. <b>2</b> wks. <b>7</b> days		IF UNDER 1 YEAR Months <b>2</b> Days <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Athol, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>SIDNEY MCCOY</b>						14. MOTHER'S MAIDEN NAME <b>BETTIE G. MCCOY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>BETTIE G. MCCOY</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia: aspiration of vomitus.</b> 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Athol</b>		(County) <b>Wicomico</b>		(State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>						DATE SIGNED <b>11-19-57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT Zion</b>		22d. LOCATION (City, town, or county) <b>SHARPTOWN</b>		(State) <b>MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>						24a. REC'D BY REGISTRAR <b>Nov 21 1957</b>					
ADDRESS <b>WEST ROAD Schisby</b>						24b. REGISTRAR'S SIGNATURE <b>May C. Owens</b>					

2082233XV2

RECEIVED  
NOV 21 1957  
BUREAU V. S.

12486

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>1200 N. Division St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>PRESTON</b> Middle <b>ROYCE</b> Last <b>MEARS JR.</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>9th</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1957</b>		9. AGE (In years lost birthday) <b>0</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>5</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md. (Hospital)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Preston Royce Mears</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ann Pusey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mr. Preston Royce Mears (Father) 1200 N. Div. St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>awaiting autopsy report</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov 4, 1957</b> to <b>Nov 9, 1957</b> , that I last saw the deceased alive on <b>Nov 9, 1957</b> , and that death occurred at <b>4:14</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>711 Camden Ave. Salisbury, Md.</b>				DATE SIGNED <b>11/12/57</b>			
ACTUAL SIGNATURE <b>Alberta Mattax</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Alberta Mattax</b>				<b>711 Camden Ave. Salisbury, Md. Nov. 1 57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR (Type REGISTRAR'S SIGNATURE) <b>Mary Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082231XV5

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form No. 10-58

**RECEIVED**  
NOV 13 1957  
BUREAU V. 3

SEE CERTIFICATE



12487

## CERTIFICATE OF DEATH

12483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O.A. at Medical Center</b>		d. STREET ADDRESS <b>% W.F. Allen Co.(Lob Lolly Lane)</b> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <b>CYNTHIA</b> Middle <b>ESTELLE</b> Last <b>MESSICK</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1957</b>
9. AGE (In years lost birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>4</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md. (Hospital)</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Arthur Amos Messick</b>	
14. MOTHER'S MAIDEN NAME <b>Patricia Murray</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr Arthur A. Messick (Father)</b> Address <b>%W.F. Allen Co. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480x</b> <b>BRONCHIAL PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INFLUENZA</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>birth</b> , 19 <b>11/12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/12</b> , 19 <b>57</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Dr. William B. Smith</b> M.D.		<b>DR. WILLIAM B. SMITH</b> The Medical Center Rt. 2, Salisbury, Md.	
PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>		<b>Salisbury, Md. 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 14, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 14 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>

2082244XV7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	

12488

## CERTIFICATE OF DEATH

12484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>—</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19th</b> Year <b>57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Unk.</b>	
9. AGE (In years last birthday) <b>About 80rs.</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Will Craig</b>				14. MOTHER'S MAIDEN NAME <b>Martha Craig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Deer's Head State Hospital, Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple osteoarthritis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 22, 1955</b> , to <b>Nov. 19, 1957</b> , that I last saw the deceased alive on <b>Nov. 19, 1957</b> , and that death occurred at <b>12:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/19/57</b>							
ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D. <b>Salisbury, Maryland</b>				DATE SIGNED <b>11/19/57</b>			
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>11-25-57</b>		<b>Deer's Head State Hospital</b>		<b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leo Res...</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>11/26/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1932	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Baltimore, Maryland		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH May 27, 1968	
13. TIME OF DEATH 10:15 AM		14. PLACE OF INTERMENT Greenwood Cemetery		15. NAME OF FUNERAL HOME None		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CORONER None		20. SIGNATURE OF REGISTRAR None	

BUREAU V. 2

NOV 27 1967

RECEIVED

## 12489 CERTIFICATE OF DEATH

12485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> <b>0913.2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>Appleby Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Robinson</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1866</b>	
9. AGE (In years lost birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>09</b> Days <b>13</b> Hours <b>2</b> Min.		IF UNDER 24 HRS. Months <b>09</b> Days <b>13</b> Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Watters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sq. cell Ca. of face</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 16, 1955</b> to <b>Nov. 25, 1957</b> , that I last saw the deceased alive on <b>Nov. 25, 1957</b> , and that death occurred at <b>9:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Maldve, M. D.</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/26/57</b>			
PHYSICIAN'S NAME (Type) <b>L. Maldve, M. D.</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-28-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/29/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>John M. [Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DEC 4 1957

BUREAU V. 2

RECEIVED

RECEIVED BOARD

24b REGISTRAR'S SIGNATURE

VS A15 (4)  
15M 9/55

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12487

12491

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Fenwick Road</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE McCABE</u> First Middle Last		4. DATE OF DEATH <u>November 2, 1957</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah McCabe</u>		14. MOTHER'S MAIDEN NAME <u>Julia Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-24-6101</u>	
17. INFORMANT <u>Lee Murray</u>		Address <u>Selbyville, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>11-2</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Men</u>	22d. LOCATION (City, town, or county) (State) <u>Selbyville, Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selbyville</u>		24a. REC'D BY REGISTRAR <u>Nov 7 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is divided into several columns and rows for detailed data entry.

BUREAU T. E.

NOV 7 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12488

## 12492 CERTIFICATE OF DEATH

Reg. Dist. No.

331

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>82 PENINSULA GEN. HOSPITAL</u>		d. STREET ADDRESS <u>308 ELIZABETH ST</u>	
3. NAME OF DECEASED (Type or print) <u>MELVIN LEE O'NEAL</u>		4. DATE OF DEATH <u>Nov. 14, 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1925</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APPLIANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>DELMAR-DE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL O'NEAL</u>		14. MOTHER'S MAIDEN NAME <u>EDITH M. HASTINGS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-07-9217</u>	
17. INFORMANT <u>Daniel F. O'Neal, Delmar Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelogenous Leukemia</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov. 14, 1957</u> to <u>Nov. 14, 1957</u> that I last saw the deceased alive on <u>Nov. 14, 1957</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel F. O'Neal</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>Nov. 14, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Albans</u>		22d. LOCATION (City, town, or county) <u>Delmar Del</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del</u>		24a. REC'D BY REGISTRAR <u>Nov 18 1957</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

BUREAU V. S.

NOV 18 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12506

## CERTIFICATE OF DEATH

Reg. Dist. No. 12489337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards (rural)</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>*****</b>		d. STREET ADDRESS <b>RFD</b>	
3. NAME OF DECEASED (Type or print) <b>STELLA C. PHILLIPS</b>		4. DATE OF DEATH <b>Nov. 7 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas W. Baker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>***</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Mr. Oliver Phillips</b>		Address <b>Willards, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Chr. Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 1957, to <b>Nov 7</b> , 1957, that I last saw the deceased alive on <b>Nov 7</b> , 1957, and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas. R. Law</b> M.D.		ADDRESS (Street, city or town, state) <b>Berlin Md</b> DATE SIGNED <b>Nov 8 - 1957</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/9/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	22d. LOCATION (City, town, or county) (State) <b>Willards, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Lillywhite Del.</b>		24a. REC'D BY REGISTRAR <b>NOV 12 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollaway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		OTHER	
WHITE		WHITE		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY		POISON		OTHER	
APR 4 1968		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO		NO		NO	
TIME OF DEATH		OCCUPATION		EDUCATION		SCHOOLING		RECORD OF DEATH		RECORD OF DEATH		RECORD OF DEATH		RECORD OF DEATH	
10:15 PM		ATTORNEY		HIGH SCHOOL		HIGH SCHOOL		RECORD OF DEATH		RECORD OF DEATH		RECORD OF DEATH		RECORD OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY	
DATE OF INTERMENT		PLACE OF INTERMENT		CAUSE OF INTERMENT		MANNER OF INTERMENT		DISEASE		INJURY		POISON		OTHER	
APR 4 1968		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO		NO		NO	
TIME OF INTERMENT		OCCUPATION		EDUCATION		SCHOOLING		RECORD OF INTERMENT		RECORD OF INTERMENT		RECORD OF INTERMENT		RECORD OF INTERMENT	
10:15 PM		ATTORNEY		HIGH SCHOOL		HIGH SCHOOL		RECORD OF INTERMENT		RECORD OF INTERMENT		RECORD OF INTERMENT		RECORD OF INTERMENT	

BUREAU V. S.

NOV 12 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>				c. LENGTH OF STAY IN 1b <b>x2</b> <b>Hebron</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main St</b>				d. STREET ADDRESS <b>1 Main St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>TOBITHA</b> Middle <b>ELLA</b> Last <b>PHILLIPS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16th</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1879</b>		9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR: Months <b>7</b> Days <b>29</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Accomac Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>George Thomas Bonnaville</b>				14. MOTHER'S MAIDEN NAME <b>Emma -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Mr. Guss Phillips (Son) Main St. Hebron, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>interior chronic Heart Disease</b> DUE TO <b>with failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>19</b> o. m. <b></b> p. m. <b></b>	Month <b></b> Day <b></b> Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>	
21. I certify that I attended the deceased from <b>11/1</b> , 19 <b>57</b> , to <b>death</b> , 19 <b></b> , that I last saw the deceased alive on <b>11/16</b> , 19 <b>57</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest M. Laimore</b>			M.D. <b>Delmar, Del</b>		DATE SIGNED <b>11/18/57</b>		
PHYSICIAN'S NAME (Type) <b>Dr. Ernest M. Laimore</b>			ADDRESS (Street, city or town, state) <b>Grove St. Delmar, Delaware</b> Nov. <b>18/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 18, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.# Salisbury Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME * SALISBURY, MD.</b>			ADDRESS <b></b>		24a. REC'D BY REGISTRAR <b></b>	24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 21 1957



BUREAU V. S.

NOV 21 1957

RECEIVED

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bradley St</b>		d. STREET ADDRESS <b>Bradley St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First XX LAURA</b>		Middle <b>TILDEN</b>		Last <b>PHIPPIN</b>	
4. DATE OF DEATH <b>NOV. 9 th 19 57</b>		Month <b>NOV.</b>		Day <b>9 th</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Sept. 9, 1876</b>		9. AGE (In years lost birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Quantico Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>James B. Phippin</b>		14. MOTHER'S MAIDEN NAME <b>Ianthia Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Thomas E. Shores (Daughter)</b> <b>Bradley St Hebron, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Oct. 30th</b> , 19 <b>57</b> , to <b>Nov. 9th</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 9th</b> , 19 <b>57</b> , and that death occurred at <b>6:10P</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Hebron Md</b>		DATE SIGNED <b>Nov. 12, 1957</b>	
ACTUAL SIGNATURE <b>William Emrich</b>		M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. William Emrich</b>		<b>Hebron, Maryland</b>		<b>Nov. /1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>Nov 13 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>James Holloway</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
ISM 9/55

REC'D BY REGISTRAR 24 REGISTRAR'S SIGNATURE  
TE NOV 13 1958 Mary Malloway

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

1-1-55-100

1. NAME OF DECEASED J. J. JONES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1-1-11-1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1-1-1-1940		9. PLACE OF MARRIAGE St. John's Church, Baltimore, Md.		10. NAME OF SPOUSE Mary J. Jones	
11. CAUSE OF DEATH Heart Disease		12. ICD-9 CODE 410.9		13. PLACE OF DEATH Home		14. DATE OF DEATH 1-1-1-1955		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. J. Jones, M.D.		17. SIGNATURE OF REGISTRAR J. J. Jones		18. SIGNATURE OF WITNESS J. J. Jones		19. SIGNATURE OF WITNESS J. J. Jones		20. SIGNATURE OF WITNESS J. J. Jones	

BUREAU V. J.

NOV 13 1957

RECEIVED

12493

## CERTIFICATE OF DEATH

Reg. Dist. No.

700

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2 yrs. 10 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>--</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>Pilkerton</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9th</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1872</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min. <b>84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tippet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Deer's Head State Hospital Records, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>9 hrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>--</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 11, 1955</b> to <b>Nov. 9, 1957</b> , that I last saw the deceased alive on <b>Nov. 9, 1957</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		DATE SIGNED <b>11/9/57</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-11-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Newport Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archard Mc Saplata md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/12/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Julia H. K...</b>		24c. REGISTRAR'S SIGNATURE <b>May H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

NOV 14 1957

RECEIVED



12494

## CERTIFICATE OF DEATH

12493

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1006 S. Division St</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>EMILY</b> Last <b>POPE</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Asbury Kelley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Esham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. William P. Pope (Husband)</b>		Address <b>1006 S. Division St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mon</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>50</b> , to <b>death</b> , 19 <b></b> , that I last saw the deceased alive on <b>11-16-57</b> , 19 <b></b> , and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lee L Lawry</b>		ADDRESS (Street, city or town, state) <b>Fruitland, Md.</b> DATE SIGNED <b>Nov. 18/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>		<b>Fruitland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 20, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>NOV 25 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary H Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1957		AT HOME	
AGE		SEX		RACE	
65		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JANUARY 1, 1892		MARYLAND		JANUARY 1, 1915	
MOTHER'S NAME		FATHER'S NAME		OCCUPATION	
JANE HARRIS		JOHN HARRIS		FARMER	
EDUCATION		RELIGION		CAUSE OF DEATH	
HIGH SCHOOL		METHODIST		HEART DISEASE	
PREVIOUS ILLNESS		TREATMENT		CERTIFICATE OF DEATH	
NONE		NONE		JANUARY 15, 1957	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF REGISTRAR	

BUREAU V. 3

NOV 25 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12495

## CERTIFICATE OF DEATH

124943 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>POINISULA GENERAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE THOMAS POWELL</u>		4. DATE OF DEATH Month Day Year <u>NOV. 4, 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9, 1863</u>
9. AGE (In years lost birthday) <u>94</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RJA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD TRUITT</u>		14. MOTHER'S MAIDEN NAME <u>MARY TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address <u>MRS. ANNIE OUTTEN, OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/4</u> , 19 <u>57</u> to <u>11/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/4</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold J. Gilmore</u>		DATE SIGNED <u>Nov 4 1957</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burky</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary McAllister</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 75

BUREAU V. S.

1957 7 NOV

RECEIVED

## CERTIFICATE OF DEATH

1249532

Reg. Dist. No.

12509

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico Rt. #1</b>				c. LENGTH OF STAY IN 1b <b>5 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Route # 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Thersa</b> Middle <b>Karen</b> Last <b>Price</b>				4. DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>F M</b>		6. COLOR OR RACE <b>AA</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/28/1957</b>	
9. AGE (In years last birthday) yrs. <b>5</b>		IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 24 HRS. Days <b>4</b> Hours <b>19</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Levin Turner</b>				14. MOTHER'S MAIDEN NAME <b>Helen Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Miss Helen Price, Quantico, Md Rt #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>480x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza Virus</b> DUE TO (c) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-28, 1957</b> , to <b>11-4, 1957</b> , that I last saw the deceased alive on <b>11-3, 1957</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur D. Browne</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Arthur D. Browne, M.D. 600 West Isabella Street, Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quantico, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. F. Stewart Funeral Home, Salisbury, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>May H. Hollings</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082223XV4



RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12496

## CERTIFICATE OF DEATH

12496

Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John W. Spacum</u>				4. DATE OF DEATH <u>November 9 - 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Seni Spacum</u>			
14. MOTHER'S MAIDEN NAME <u>Norothy Huffard</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>716-03-1600</u>				17. INFORMANT <u>Adah Spacum - Selma Earl</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Benign Prostatic Hypertrophy</u> DUE TO (c) <u>2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct 28</u> , 19 <u>57</u> , to <u>Nov 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>57</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B Long</u> M.D.				ADDRESS (Street, city or town, state) <u>Med Center Salisbury Md</u> DATE SIGNED <u>11/10/57</u>			
PHYSICIAN'S NAME (Type) <u>W. S. Marvel Co - Selma Earl</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>11-12-57</u>				22c. NAME OF CEMETERY OR CREMATORIUM <u>First Methodist</u>			
22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>				24a. REC'D BY REGISTRAR <u>Nov 13 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

File No.

NAME

WILLIAM

DATE OF BIRTH

1910

PLACE OF BIRTH

INDIANA

EDUCATION

HIGH SCHOOL

RELIGION

METHODIST

CAUSE OF DEATH

HEART DISEASE

PERIOD OF ILLNESS

2 WEEKS

DATE OF DEATH

1957

PLACE OF DEATH

HOSPITAL

DATE OF INTERMENT

1957

PLACE OF INTERMENT

CATHOLIC

DATE OF BURIAL

1957

PLACE OF BURIAL

CATHOLIC

DATE OF CREMATION

1957

PLACE OF CREMATION

CATHOLIC

DATE OF EXHUMATION

1957

PLACE OF EXHUMATION

CATHOLIC

DATE OF REINTERMENT

1957

PLACE OF REINTERMENT

CATHOLIC

DATE OF RECREMATION

1957

PLACE OF RECREMATION

CATHOLIC

DATE OF REBURIAL

1957

PLACE OF REBURIAL

CATHOLIC

DATE OF REINTERMENT

1957

PLACE OF REINTERMENT

CATHOLIC

DATE OF RECREMATION

1957

PLACE OF RECREMATION

CATHOLIC

DATE OF REBURIAL

1957

PLACE OF REBURIAL

CATHOLIC

DATE OF REINTERMENT

1957

PLACE OF REINTERMENT

CATHOLIC

BUREAU A. 3

NOV 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12497

## CERTIFICATE OF DEATH

12497

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pen. Gen. Hospital</u>				d. STREET ADDRESS <u>Main St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LIZZIE</u> Middle <u>ELLEN</u> Last <u>SOLLOWAY</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>19th</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>R.D. # Mardela Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John P. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Jane Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mary T. Brown (Sister)</u> Address <u>Mardela, Maryland</u> Box # <u>27</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Uremia</u> <u>155X</u> DUE TO (b) <u>Generalized Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma of Gall Bladder</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-13-</u> 19 <u>57</u> , to <u>11-19-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11-19-</u> 19 <u>57</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H. Cayaves</u> M.D.				ADDRESS (Street, city or town, state) <u>222 N. Division St., Salisbury, Md.</u> DATE SIGNED <u>11/19/57</u>			
PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES, M.D.</u>				224 N. Division St. Salisbury Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mardela Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Nov 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach this certificate for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

NOV 21 1957

RECEIVED



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filled with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12498 Item 7 Film G223 12-5-57 et  
**CERTIFICATE OF DEATH**

12498/

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 yr 10½ mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS --			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>--</b> Last <b>Spencer</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18th</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GANNING FACTORY</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unk.</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>213-22-7775</b>		17. INFORMANT <b>Deer's Head State Hospital Records, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>132x</b>							INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>19</b>	Day <b>19</b>	Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Salisbury, Maryland</b>	(County) (State)
21. I certify that I attended the deceased from <b>Jan. 3, 1955</b> to <b>Nov. 18, 1957</b> , that I last saw the deceased alive on <b>Nov. 18, 1957</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. Kosmahly</b>				DATE SIGNED <b>11/19/57</b>			
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>				<b>Deer's Head State Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11.23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>JOHN WESLEY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr.</b>				24a. REC'D BY REGISTRAR <b>DATE 12/2/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

BUREAU V. S.

DEC 3 1957

RECEIVED

12499

CERTIFICATE OF DEATH

12499

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland 6</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>401 Race St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>THOMAS</b> Middle <b>PETER</b> Last <b>STEELE</b>		4. DATE OF DEATH		Month <b>NOVEMBER</b> Day <b>3 rd</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1895</b>		9. AGE (In years lost birthday) <b>62</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Boys <b>8</b> Hours <b>8</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Laborer of Gen. Outdoors Adv.Co.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Isaac Steele</b>				14. MOTHER'S MAIDEN NAME <b>Unk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>223-10-2299</b>		17. INFORMANT <b>Mr. Thomas P. Steele Jr.</b> Address <b>401 Race St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchitis</b> <b>502x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/10</b> , 19 <b>50</b> , to <b>11/3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/3/50</b> , 19 <b>57</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>F. R. Gramse</b>				M.D. <b>S. Division St Salisbury, Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Fred Gramse</b>				Nov. <b>11</b> 19 <b>57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24. RECEIVED BY REGISTRAR <b>NOV 8 1957</b> 25. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1957-000-000

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JANUARY 10, 1933		MOBILE, ALABAMA	
MARRIAGE DATE		MARRIAGE PLACE	
-		-	
OCCUPATION		EDUCATION	
Attorney		High School	
CAUSE OF DEATH		MANNER OF DEATH	
Suicide by gunshot		Accident	
PLACE OF DEATH		CITY	
MEMPHIS, TENNESSEE		MEMPHIS	
COUNTY		STATE	
SHELBY		TENNESSEE	
DECEASED'S RESIDENCE		DECEASED'S ADDRESS	
MEMPHIS, TENNESSEE		312 E. BAYVIEW AVE.	
DECEASED'S OCCUPATION		DECEASED'S EMPLOYER	
Attorney		-	
DECEASED'S MARITAL STATUS		DECEASED'S RELIGION	
Single		Methodist	
DECEASED'S BIRTH DATE		DECEASED'S BIRTH PLACE	
JANUARY 10, 1933		MOBILE, ALABAMA	
DECEASED'S MARRIAGE DATE		DECEASED'S MARRIAGE PLACE	
-		-	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION	
Attorney		High School	

BUREAU V. S.

NOV 8 1957

RECEIVED

## 12510 CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>X/</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 2 Springhill Road.</b>		d. STREET ADDRESS <b>Route # 2 Springhill Road.</b>	
e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>George</b> Last <b>Thomas</b>		4. DATE OF DEATH Nov. Month <b>1.</b> Day <b>1957.</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 24. 1873.</b>
9. AGE (In years and birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prof. Dynamiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blasting.</b>	
11. BIRTHPLACE (State or foreign country) <b>Burns, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James B. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Burt Thomas (Son) Hebron, Maryland.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> to <b>11-1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-31-</b> 19 <b>57</b> , and that death occurred at <b>7.05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Phillip A. Insley</b> M.D. <b>Salisbury Md 11-1-57</b> PHYSICIAN'S NAME (Type) <b>Dr. Phillip A. Insley 116 E. Main St. Salisbury, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 4. 57.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hebron Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Hebron, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Company Salisbury, Maryland.</b>		ADDRESS <b>Holloway &amp; Company Salisbury, Maryland.</b>	
24a. REC'D BY REGISTRAR DATE <b>11-1 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, is 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

NOV 7 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12500

## CERTIFICATE OF DEATH

Reg. Dist. No.

12501 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN. GEN. HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patricia</u> First <u>Doody</u> Middle <u>Truitt</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 22, 1914</u> yrs.	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>PATRICK HENRY DOODY</u>				14. MOTHER'S MAIDEN NAME <u>ELDISE MY BRIETY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>KING TRUITT - SAME</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Congestive Failure &amp; Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhages from Esophageal Varices</u> (c) <u>Cirrhosis of Liver</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-1</u> , 1957, to <u>11-2</u> , 1957, that I last saw the deceased alive on <u>11-2</u> , 1957, and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>DR. WILLIAM B. SMITH The Medical Center 2, Salisbury, Md.</u>			
DATE SIGNED <u>11/4/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11/5/1957</u>		<u>PARSONS CEMETERY</u>		<u>SALISBURY, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Johnson</u> ADDRESS <u>SALISBURY, MD</u>				24a. REC'D BY REGISTRAR DATE <u>11-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holliday</u>	

WYOMING STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

1961 2 MON

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12502 12501 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>23x0.2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>R.D. # 3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELIZABETH</b> Last <b>TRUITT</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>13</b> Year <b>th 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>72</b>	IF UNDER 24 HRS. Days <b>72</b> Hours <b>72</b> Min. <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Parsonsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Rufus Evans</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Briddell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Kendall J. Truitt (Son)</b> Address <b>S. Main St. Berlin, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive and degenerative</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Under 1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>11-13</b> , 19 <b>57</b> , and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>William R. Ellis Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis Jr.</b>				Medical Center- <b>Salisbury, Maryland Nov. 13, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 16, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parsonsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>NOV 15 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 15 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Accomack</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 23x0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 N. Park Drive</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>A.</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30-1869</u>
9. AGE (In years last birthday) <u>88 1/2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William H. Brimes</u>		14. MOTHER'S MAIDEN NAME <u>Martha Sheppard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Walter Saylors</u> Address <u>Salisbury, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22/57</u> , 19 <u>57</u> , to <u>11/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.</u> M., from the causes and on the date stated above. <u>11/28/57</u> ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. C. Mitchell</u> M.D. PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Worcester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Sumner</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

BUREAU V. S.

DEC 3 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12503

## CERTIFICATE OF DEATH

12504

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin, Md.</u> 23X0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>BABY</u>				4. DATE OF DEATH <u>November 3- 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 2, 1957</u>	
9. AGE (In years last birthday) <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ROLAND WHITTINGTON</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH TAYLOR</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>MR. ROLAND WHITTINGTON</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Cerebral Tumor</u> DUE TO <u>Prematurity (1050 grams)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Nov 2</u> , 19 <u>57</u> , to <u>Nov 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>57</u> , and that death occurred at <u>7:30 AM</u> M, from the causes and on the date stated above.			
21. ACTUAL SIGNATURE <u>Alfred C. Kello</u> M.D.				21. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>			
21. PHYSICIAN'S NAME (Type) <u>Alfred C. Kello</u>				21. DATE SIGNED <u>11/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>NOV 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallway</u>	

2082344 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

1525

Brady, J. H. 1881

— 100 —

11. Leftist - not rightist

There is a lot of

**BUREAU V. S.**

NOV 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12504

CERTIFICATE OF DEATH

12505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>5 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. STREET ADDRESS <b>720 Greenwood Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>S.</b> Last <b>Zimmerman</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/13/1892</b>	
9. AGE (In years lost birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>22</b>		11. IF UNDER 24 HRS. Hours <b>00</b> Min. <b>00</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Edward Bartling</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Kreusler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> <b>181X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ca. of bladder</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 21, 1957</b> , to <b>Nov. 25, 1957</b> , that I last saw the deceased alive on <b>Nov. 25, 1957</b> , and that death occurred at <b>8:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/26/57</b>							
ACTUAL SIGNATURE <b>L. V. Maldve, M. D.</b>				M.D. <b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>				24a. REC'D BY REGISTRAR <b>Nov 27 1957</b>			
ADDRESS <b>4101 Edmondson Ave.</b>				24b. REGISTRAR'S SIGNATURE <b>Mary Hallway</b>			



STATE DEPARTMENT OF HEALTH—BATHING

1957 26 Nov

RECEIVED